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IN THE

Supreme Court Of The United States

OCTOBER TERM, 1973

No. 73-1381

ATKINSON-DAUKSCH AGENCIES, INC.,
Plaintiff-Petitioner,

v.

JOHN HANCOCK MUTUAL LIFE INSURANCE
Defendant-Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS, SIXTH CIRCUIT
BRIEF FOR RESPONDENT IN OPPOSITION

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STATEMENT OF THE CASE

There are no disputed questions of fact in this case. Most of the facts were stipulated by counsel. Atkinson-Dauksch Agencies, Inc., plaintiff, made an application to John Hancock Mutual Life Insurance Company, defendant, on September 24, 1968 for insurance in the amount of Two Hundred Thousand Dollars ($200,000) on the life of plaintiff's president, Robert O. Miller. No part of any premium was paid to the defendant at the time the application was made. The contractual provision is correctly set forth in plaintiff's petition herein and provides that the policy shall take effect on delivery

and payment of the premium and only if at the time of such delivery and payment the proposed insured has not consulted, been examined or been treated by a physician or practitioner since the application was completed.

It was further stipulated that Robert Miller was examined and treated by a physician twice on either October 5 or October 6, 1968 and that he was treated by another physician several times on each of the days October 6, October 7, October 8 and October 9 and was confined to a hospital from October 6 at 2:40 P.M. to October 9. It was further stipulated that neither Robert O. Miller nor plaintiff told defendant on or before October 14, 1968 any of these facts respecting treatment and confinement and that at the time of the delivery of the policy on October 14, 1968 defendant did not know any of those facts.

The depositions and answers to interrogatories which were filed in this case comprise the rest of the record. They show that in 1965 plaintiff inquired of defendant as to the possibility of getting insurance on the life of Robert Miller. The statement of his attending physician, Dr. Clouse, showed that at that time Miller had a history of high blood pressure running as high as 180/100. The inquiry was not pursued and no application for insurance was made in 1965 and no insurance policy was issued.

In 1968, when the inquiry was renewed, Dr. Clouse submitted a statement to defendant wherein he stated that under medication Miller's blood pressure had been reduced so that the three readings in January, March and May of 1968 were all 140/90. Dr. Clouse further stated in said communication that Mr. Miller's present condition of health was "excellent."

Defendant indicated that it would consider insurance but that it would have to be written at a substandard rate because of the history of hypertension. Thereupon the application for the insurance was made by plaintiff to defendant.

On October 4, 1968 Mr. Miller went to an insurance convention in White Sulphur Springs. In the middle of the night (October 5-6) after he had arrived at the convention, while in his room at The Greenbrier, he had severe pains in his stomach and Dr. Brody, the house physician, was called. He spent about an hour with Mr. Miller and the next morning had an electrocardiogram taken in the facilities at the hotel. The electrocardiogram made Dr. Brody feel that Mr. Miller should be hospitalized and he was sent to the Chesapeake & Ohio Hospital at Clifton Forge, Virginia, which is about 30 miles away from White Sulphur Springs. Miller arrived at the hospital at 2:40 P.M. on October 6 and remained there until sometime on October 9, 1968 in the coronary unit of the hospital.

Dr. Ballou, who was in charge of the hospital, saw Miller three or four times a day and had three electrocardiograms taken on successive days. The electrocardiogram taken on October 8 showed for the first time an inversion of the T wave, which made Dr. Ballou feel that coronary insufficiency had developed and that Miller was possibly in danger of an impending infarction. Dr. Ballou testified about what he told Miller.

> "It was explained to him that he had a hiatus hernia which we have talked about, and that he also had coronary insufficiency, which had caused his pain, and also he had a spasm of his stomach which had also possibly caused his pain. But, in view of the electrocardiogram changes, we felt that he needed to be immediately hospitalized at home to go under

his doctor's care, and we advised him to continue his anticoagulant therapy so that his doctor could pick this up just where we had left off."

On October 9, 1968 Miller was taken back to Columbus. He didn't go to his doctor until October 14, 1968. On October 14, the policy of insurance was delivered to Miller as president of plaintiff. Miller did not tell John Hancock anything about his treatment or hospitalization described above. Within one and one-half hours after the policy was delivered, Miller went to see his doctor, Dr. Clouse, and told Dr. Clouse about the treatment and hospitalization described above.

Miller died on October 16, 1968 and Dr. Clouse executed a death certificate which is in the record in which he stated

"Immediate cause of death myocardial infarction.

"Approximate interval between onset and death 1½ hr.

"Due to coronary artery disease

"Approximate interval between onset and death 10 days."

Plaintiff, in its petition for writ of certiorari, states three questions presented for review.

ARGUMENT ON QUESTION 1

The first question relates to the validity of the provision that the insurance shall only take effect if the proposed insured has not consulted, been examined or been treated by a physician since the application was completed. The law on this question is so well established that there is no need for this Court to review it.

Subar v. New York Life Ins. Co., 60 F 2d 239 (1932) CC 6. *Natcchio v. New York Life Ins. Co.*, 200 F 2d 770

(1952) CC 3. *New York Life Ins. Co. v. Gist*, 63 F 2d 732 (1933) CC 9. *Hurt v. New York Life Ins. Co.*, 51 F 2d 936 (1931) CC 10. Certiorari denied 285 US 541.

All of these cases considered the validity of the contractual provision. All of these cases held the provision to be valid.

In *Girouard v. John Hancock Mutual Life Ins. Co.*, 98 RI 1, 199 Atl 2 307 (1964), the Supreme Court of Rhode Island, in coming to the same conclusion, stated, at page 309, concerning the federal authorities:

> "In addition the Circuit Courts of Appeal in the Second, Third, Sixth, Eighth and Tenth Circuits have reached like conclusions as did the Court in the Ninth Circuit in New York Life Insurance Company v. Gist.'

Plaintiff has cited no cases in which it was held that this provision was not valid.

ARGUMENT ON QUESTION 2

The second question which plaintiff says is presented by this case is whether the insurance company can take advantage of the contractual provision here involved when the company is aware of a pre-existing health condition which creates additional risk of early death and where the insurance company charged a substandard preium higher than normal. So far as we know, no one has ever advanced this argument before. If it were sustained, it would discourage the writing of substandard insurance. There is no reason for the courts to frown on substandard insurance. Mr. Miller had a history of hypertension, which was controlled by medication, and his doctor certified that his physical condition was excellent. The company, like everyone else, knew that a con-

dition of hypertension, even when controlled, tends to reduce the length of life expectancy. Everyone also knows that many policies are issued on substandard risks. Why should an insurer be less entitled to know of intervening medical treatment and hospitalization with respect to a substandard applicant than with respect to a normal applicant? It seems that the converse of this is true.

Plaintiff in this case was a large insurance agency and Mr. Miller was obviously sophisticated in the field of insurance. Plaintiff had a choice: By paying the premium at the time the application was made, plaintiff could have imposed on the insurance company the risk of any intervening medical treatment being required before the policy was delivered and the premium paid. Or. plaintiff, by chosing not to pay the premium until delivery, could itself assume the risk of intervening medical treatment being required. There is no reason why such a choice should not be made by an applicant for insurance. Plaintiff chose not to pay the premium at the time the application was made and consequently plaintiff bore the risk of the policy not becoming effective by reason of intervening medical treatment. This answers question 2 presented by the plaintiff.

ARGUMENT ON QUESTION 3

Plaintiff states as question 3 whether medical testimony that the insured was in good health at the time of delivery prevents a summary judgment and refers to certain Ohio statutes. With respect to the condition of health of the plaintiff at the time of the delivery of the policy, the death certificate of Dr. Clouse showing that the coronary artery disease arose 10 days before date of death, i.e. on October 6, 1968, is a complete answer.

The Ohio statutes quoted on pages 9 and 10 of plaintiff's petition show on their face that they deal only with errors, omissions and misstatements contained in an application. These statutes are not applicable to the present case because no claim is made by the defendant that any misstatements were contained in the application. This is not a case involving a claim of fraud. This is a case which deals with a contractual provision.

Judge Kinneary of the District Court disposed of this argument in his opinion as follows:

> "The defendant has not alleged fraud on anyone's part. Defendant has merely stated that Miller's receipt of medical treatment after the filing of the application constitutes a contingency whose occurrence, by the expressed language of the application, precludes the policy from taking effect." Citing Subar v. N. Y. Life Ins. Co. (supra).

The Circuit Court of Appeals toward the end of its opinion states:

> "The issue to be here decided is not one of fraud or misrepresentation but one of contract law by agreement between sophisticated parties."

DISCUSSION OF CASES CITED BY PLAINTIFF

Plaintiff cites two Ohio cases—*Metropolitan Life Ins. Co. v. Howle*, 62 OS 204, and *Metropolitan Life Ins. Co. v. Howle*, 68 OS 614, asserting that they require that the case be submitted to a jury. Both of these cases involve contractual provisions that the policy was not to go into effect unless on the date of delivery the applicant was alive and in sound health. The court in those cases held that fraud or knowledge on the part of the applicant as to his unsound condition of health was not material, the only question being whether the insured was **in fact**

in sound health at the time of the delivery of the policy. The reason that the cases were submitted to the jury was because there was conflicting evidence as to the soundness of the applicant's health at the date of delivery.

In our case, there is no dispute in the evidence as to the medical treatment of Mr. Miller between the date of the application and the date of delivery. It was stipulated by parties. Consequently, there was nothing to submit to a jury.

Plaintiff cites *Major Oil Corp. v. Equitable Life Assurance Society*, 457 F 2d 596. This case does not involve the contractual provision under consideration in the case at bar. Because of this, the Circuit Court of Appeals for the Tenth District did not find it necessary to discuss or comment on *Hurt v. New York Life Ins. Co.*, 51 F 2d 936, decided by the Circuit Court of Appeals of the Tenth District, which enforced a contractual provision almost identical to that involved in the case at bar. Furthermore, the evidence in the *Major Oil* case showed that the insurance company knew of, or had reason to know of, the physical condition and treatment of the applicant. In our case Miller and the plaintiff did not disclose the intervening medical treatment to the defendant and it is stipulated that the defendant *did not know of such treatment.*

Plaintiff, at pages 7 and 8, cites a number of cases from states other than Ohio. Many of these cases involve defenses of fraud in the applications. *Subar* shows that they are not applicable. Several of the cases involve sound health clauses as given in effect in those states. The *Howle* cases (supra), decided by the Supreme Court of Ohio, show that lack of knowledge of the insured with respect to his condition of health is of no significance.

While defendant insists that, under the Federal authorities and the Ohio authorities, the fact of treatment controls rather than the knowledge of the insured, we cannot refrain from pointing out the following:

Miller, president of the applicant, knew he had spent four days in the hospital under constant treatment by Dr. Ballou in October after the application was made and before the policy was delivered. He disclosed this knowledge to his own doctor one and one-half hours after the policy was delivered. It was stipulated that he did not tell the defendant anything about that medical treatment or hospitalization. It is absurd for the plaintiff to claim that it did not know of the medical treatment and hospitalization.

The Supreme Court of the United States has clearly stated in *Stipcich v. Metropolitan Life Ins. Co.*, 277 US 311, 72 LE 895 (1927) that an applicant for insurance who discovers a change in his physical condition seriously affecting his health and rendering statements in his application no longer true is under a duty to the insurer fully to disclose the facts and his failure to do so will constitute a defense on an action on the policy.

While no contractual provision was involved in *Stipcich*, the law as announced in *Stipcich* certainly supports the rationale of the many federal cases enforcing the contractual provision involved in our case. It will also be noted in *Stipcich* that Stipcich suffered a *recurrence* of a duodenal ulcer after applying for insurance before the delivery of the policy. This shows that the knowledge of the defendant that Miller had for many years had hypertension does not detract from the controlling significance of his medical treatment and hospitalization between the date of the application and the delivery of the policy.

CONCLUSION

There is no reason for this Court to reconsider questions of the type involved in the case at bar. There is no conflict in the Federal authorities or in the Ohio authorities. The principles applied by the lower courts are well established and require no further consideration. It is, therefore, submitted that plaintiff's petition for a writ of certiorari be denied.

Respectfully submitted,
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AFFIDAVIT OF SERVICE

STATE OF OHIO)
FRANKLIN COUNTY) SS.

The undersigned, Herbert R. Brown, attorney for Respondent, John Hancock Mutual Life Insurance Company, states that he has on the 3rd day of April, 1974, served by mail three printed copies of the foregoing Brief for Respondent in Opposition to the Petition for Certiorari to the United States Court of Appeals, Sixth Circuit, on Mr. Jack R. Alton, of Lane, Alton & Horst, 150 East Broad Street, Columbus, Ohio 43215, attorney for Petitioner, Atkinson-Dauksch Agencies, Inc., being all parties required to be served.

Herbert R. Brown

Sworn and subscribed to before me this 3rd day of April, 1974.

Dorothy D. Eye Notary Public
Franklin County, Ohio
Comm. Exp. 8-1-77